Referral Application

Please fill out the entire application and verify each section before submitting.
Note: Information marked with an * will be used on the organizations page at www.centers.rainn.org

### Organization's Contact Information

<table>
<thead>
<tr>
<th><strong>Organization Name</strong></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Mailing Address</td>
<td></td>
</tr>
<tr>
<td>*City, State, Zip Code</td>
<td></td>
</tr>
<tr>
<td>*Counties the organization serves</td>
<td></td>
</tr>
<tr>
<td>*Business Phone Number</td>
<td></td>
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<tr>
<td>*Organization's Website</td>
<td></td>
</tr>
<tr>
<td>CEO/Executive Director’s Name</td>
<td></td>
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<tr>
<td>CEO/Executive Director’s Email Address</td>
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</tbody>
</table>

### Primary Contact’s Information

<table>
<thead>
<tr>
<th>Executive Director or Manager</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td></td>
</tr>
<tr>
<td>Contact Phone Number</td>
<td></td>
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<tr>
<td>Email Address</td>
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</table>

### Secondary Contact’s Information

<table>
<thead>
<tr>
<th>Volunteer Coordinator or Manager</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td></td>
</tr>
<tr>
<td>Contact Phone Number</td>
<td></td>
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<tr>
<td>Email Address</td>
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</tbody>
</table>
**Hotline Information**

<table>
<thead>
<tr>
<th>*Hotline Phone Number</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>What percentage of the hotline calls you receive are related to sexual assault?</td>
<td></td>
</tr>
<tr>
<td>Does the hotline operate 24 hours a day, 7 days a week?</td>
<td></td>
</tr>
<tr>
<td>If yes, is the hotline answered by your staff/volunteers 24/7, or is it routed to another organization after hours? Please describe.</td>
<td></td>
</tr>
<tr>
<td>Does the organization provide chat or web-based services? If yes, please describe.</td>
<td></td>
</tr>
<tr>
<td>Are criminal background checks conducted on all staff and volunteers?</td>
<td></td>
</tr>
<tr>
<td>Does the organization have a written policy stating compliance with states’ mandatory reporting laws?</td>
<td></td>
</tr>
</tbody>
</table>

**Information on Services**

Are there any eligibility requirements for that someone calling your hotline must meet to use your services. Please describe in 1-2 sentences below.

________________________________________________________________________

Does your organization provide services to male survivors? Please describe.

________________________________________________________________________

Are there any specific populations that your advocates have expertise in assisting?

________________________________________________________________________

What services do you offer in Spanish?

________________________________________________________________________
Do you offer services in any other language? If yes, please describe.

[Blank space for description]

Are translators available over the phone and/or in person? Please describe.

[Blank space for description]

What kinds of accommodations is your center able to make for survivors with disabilities? Please describe.

[Blank space for description]

What services are available for deaf and hard of hearing survivors?

[Blank space for description]

Please list all of the counties you serve:

[Blank space for description]

**Staff Training**

How does the organization train their staff and volunteer counselors/advocates to meet the diverse needs of sexual assault survivors?

[Blank space for description]

How many hours are required PROVIDED?
Did a mental health professional design the training?


Does your center require advocates to have specific training in supporting survivors with disabilities? If yes, please describe:


Please describe any staff/volunteer training that addresses the needs of lesbian, gay, bisexual, and queer sexual assault survivors


Please describe any staff/volunteer training that addresses the needs of transgender and non-binary sexual assault survivors


Please describe any staff/volunteer training that addresses the needs of sexual assault survivors with mental health conditions


How often do you require staff to complete continuing education or refresher trainings? Please describe.


Collaboration with the State Coalition

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the organization a member of the state coalition?</td>
<td></td>
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<tr>
<td>If no, please explain.</td>
<td></td>
</tr>
<tr>
<td>How long has the organization been a member of the state coalition?</td>
<td></td>
</tr>
<tr>
<td>Is the organization in compliance with state, county, and local statutes and regulations governing your operations?</td>
<td></td>
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<tr>
<td>Is the organization affiliated or certified by any other organizations or accrediting bodies, such as the National Children’s Alliance or Tribal Coalitions?</td>
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</table>

*Are the organizations staff/volunteers trained to provide services to any of the following populations?*

- ☐ Children
- ☐ Adolescents
- ☐ Older Adults
- ☐ Men
- ☐ Survivors of military sexual trauma
- ☐ Transgender/Non-binary/Two-Spirit
- ☐ LGB/Queer
- ☐ Spanish speakers
- ☐ Non-English or non-Spanish speakers
- ☐ Students
- ☐ Adults abused/assaulted as children
- ☐ Intimate partner violence/domestic violence
- ☐ Deaf and Hard of Hearing
- ☐ Adult incest survivors
- ☐ Cyber crimes
- ☐ Harmful traditional practices
- ☐ Sexual harassment
- ☐ Human trafficking
*Please indicate below what services are offered by your organization:

☐ 24 Hour Hotline ☐ Case Management ☐ Child Advocacy Center

☐ Community Education ☐ Counseling/Emotional Support ☐ Crime Victim Assistance Advocacy

☐ Career Services ☐ Emergency Transportation ☐ Emergency Shelter

☐ Financial Education ☐ Hospital Accompaniment ☐ Legal Advocacy

☐ Local Referrals ☐ Medical Attention/Evidence Collection ☐ Mental Health Services

☐ Online Chat ☐ Online Support Groups ☐ Parent Support Services

☐ Peer Support Groups ☐ Safety Planning ☐ Safety Programming for Children

☐ Sign-Language Interpreters ☐ Survivor Support Groups ☐ Substance Use Support

☐ Support Groups for Loved Ones ☐ Talking Circles ☐ TTY/Video Phone

☐ Wheel-Chair Accessible Facility ☐ Youth Support Groups ☐ Financial Education

We are excited about your interest be a referral organization with RAINN. Below, please share with us why you are interested in partnering with RAINN and how RAINN can assist the organization’s efforts to support survivors of sexual violence:


RAINN Confidentiality Policy
Referral organizations will respect client’s rights to confidentiality and will adhere to a confidentiality policy that includes the following items:

- A client will never be pressured into revealing their identity.
- Victim records will not be released without the consent of the victim, except when an organization is obligated by law.
- Reports of the assault will be made to police or other agencies only with the client’s consent, except when an organization is obligated by law to report the attack.

I affirm that, as a referral organization, my organization will adhere to the confidentiality policy above.

Executive Director/CEO’s Initials: __________________ Date: ______________

RAINN Non-Discrimination Policy
Referral organizations shall not discriminate against any individual for reasons of race, color, creed, religion, sexual orientation, gender identity, national origin, sex, age, language, disability or political party identification. Accordingly, equal access to employment opportunities and services is extended to all persons.

I affirm that, as a referral organization, my organization will adhere to the non-discrimination policy above.

Executive Director/CEO’s Initials: __________________ Date: ______________

By Signing below and submitting this application affirm that all answers state in this application are true; that your organization provides free, or low cost, services to all survivors of sexual assault without discrimination on any basis; and that you will abide by the confidentiality policy.

Name of CEO/Executive Director (please print): _____________________________

Signature of CEO/Executive Director: ______________________ Date: __________

Please return completed application to the RAINN NSAH Affiliate and Resources Manager:
Email: MiaN@rainn.org
Fax: 202.544.3556, Mail: RAINN 1220 L St NW, Suite 505, Washington, DC 20005
Questions? Call the NSAH Director at: 202-751-3220